III. METHOD FOR REIMBURSEMENT TO INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

A. INTRODUCTION

Intermediate Care Facilities for the Mentally Retarded (ICF/MR) are defined as intermediate care facilities whose primary purpose is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions and which meet the standards in Subpart D or Part 483 of the Code of Federal Regulations.

The State classifies treatment services by individual level of care (LOC) needed to meet the medical needs of eligible recipients. Six levels of care (2-7) have been established based upon recipient profiles (Individuals who are not in need of institutional care comprise Level 1). These levels are described as follows:

- LOC 2 Requires minimal supervision and care and little or no medical attention for physical problems. Specific treatment(s) is given for specific problems of a mental and/or physical nature.

- LOC 3 Requires minimal to moderate supervision and care and possesses no significant medical disabilities. Planned rehabilitation and treatment programs are usually of a recreational or therapeutic nature and counseling and psychotherapy may be given. Habit training is also required.

- LOC 4 Requires minimal to moderate supervision and may posses medical disabilities. Planned rehabilitation and treatment programs may include academic and recreational services, as well as specific treatments for emotional, mental, behavioral and/or physical disabilities.

- LOC 5 Requires moderate supervision and some severe disabilities are usually present. Clients require some degree of intensive medical, psychiatric or psychological treatment.

- LOC 6 Requires close supervision. Clients require intensive, medical, psychiatric or psychological treatment.

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- LOC 7 Population is non-ambulatory and requires total care including intensive medical, psychiatric, or psychological treatment.

B. PROVIDER GROUPING

Providers are divided into two major groups, Public and Private, with three sub-groupings for Private providers based upon facility capacity (the number of beds licensed/approved by the State for provision of ICF/MR services). Private providers are reimbursed based upon a flat prospective rate by Capacity/LOC grouping which is subject to annual inflation adjustment. (Public providers are reimbursed a facility specific prospective rate based on budgeted costs.)

Public ICF/MR Facilities

Included under this classification are State operated facilities.

Private ICF/MR Facilities

Included under this classification are private proprietary and nonprofit facilities who are grouped based upon bed capacity and level of care. Bed capacity and level of care classifications are as follows:

- Capacity of 1-8 beds, Levels of care 2 through 7
- Capacity of 9-32 beds, Levels of care 2 through 7
- Capacity of 33 beds and over, Levels of care 2 through 7

C. REIMBURSEMENT TO PRIVATE ICF/MR PROVIDERS

1. Cost Determination Definitions

a. CPI - All Items - The Consumer Price Index (CPI) for all Urban Consumers-South Region (All Items line) for December as published by the United States Department of Labor.

b. Economic Adjustment Factor - The CPI All Items Factor is computed by dividing the value of the corresponding Index for December of the year preceding the Rate year by the value of the Index one year earlier (December of the 2nd preceding year).

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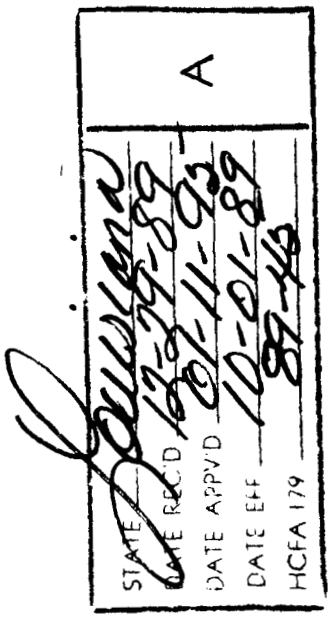
c. Rate Year - The rate year is the one year period from July 1 through June 30 of the next calendar year during which a particular set of rates is in effect. It corresponds to the State's fiscal year.

d. Base Rates - Base rates were established by assigning each facility to a Capacity/LOC grouping and averaging each facility's issued rate for July 1, 1987 within that group.

e. Fixed Cost - Interest from line item C-1-17 (Interest (other than capital assets)) and capital costs from Line C-1-52 (Total Cost related to Capital Assets) of the cost report.

f. Non-Fixed Cost - All other costs not captured in Fixed Cost above.

g. Base Rate Components - Base rates are the summation of the components shown below. Each base rate component is intended to reimburse for the costs indicated by its name. Both cost component amounts are based on averages by facility size grouping and LOC for the base year.



Base Rate Component Economic Adjustment Factor

Non-Fixed Cost Items	CPI - All Items
Fixed Cost	None (1)
Return on Investment	None (2)

(1) No inflation allowed.

(2) Adjusted by a return on investment (ROI) factor of 5%

2. Cost Reporting Requirements

a. Initial Reporting

The initial cost report must contain costs for a full twelve-month period and be reported on the State's fiscal year of July 1 through June 30.

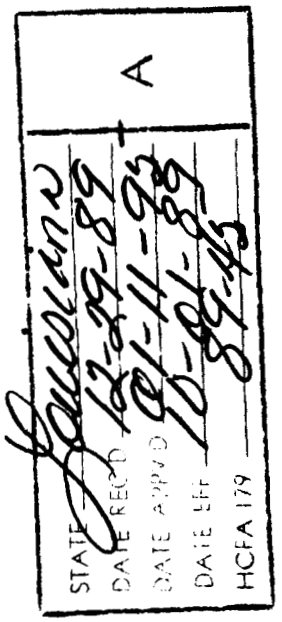
b. Subsequent Reports

Each provider shall submit an annual cost report for fiscal year ending June 30. These cost reports shall be filed by September 30, ninety (90) days after the State's fiscal year end.

c. Exceptions

Limited exceptions to the report requirement will be considered on an individual facility basis upon written request from the provider to the Director of Institutional Reimbursement of DHH, Bureau of Health Services Financing. If an exception is allowed, providers must attach a statement describing fully the nature for the exception request. The extension must be requested by September 30.

If a facility is new, it will not be required to file a cost report for rate setting purposes until one full rate year is completed. Facilities purchased as on-going concerns are not considered new facilities for cost reporting purposes.



3. Increased Capacity

Increased bed capacity requires approval from Bureau of Health Services Financing.

4. Sales of Facilities

In the event of the sale of a ICF/MR facility, the seller is required to submit a cost report from July to the date of sale.

If the purchaser continues the operation of the facility as a provider of ICF/MR services, he is required to furnish an initial cost report covering the date of purchase to June 30. Thereafter, the facility will file an annual July 1 through June 30 cost report.

5. New Facilities

A provider entering the ICF/MR Program is paid the applicable facility rate. There is no retroactive adjustment for either overpayment or underpayment to the facility.

6. Interim Adjustment to Base Rates

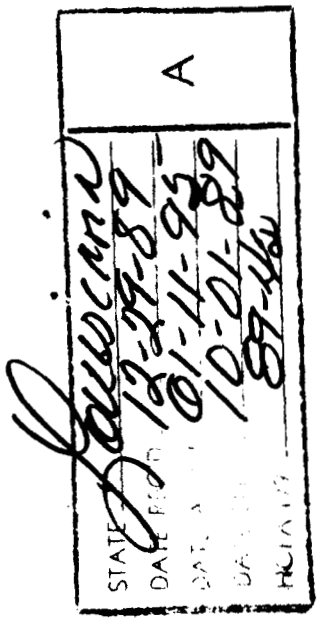
If an unanticipated change in conditions occurs which affects the cost of a level of care of at least fifty percent (50%) of the enrolled long term care facilities by an average of five percent (5%) or more, the rate may be changed. The Bureau of Health Services Financing will determine whether or not the rates should be changed when requested to do so by ten percent (10%) or more of the enrolled providers. The burden of proof as to the extent and cost effect of the unanticipated change will rest with the providers requesting the change. In computing the costs, all capital expenditures will be converted to interest and depreciation. The Bureau of Health Services Financing, however, may initiate a rate change without a request to do so in the event new Federal or State rules, regulations or laws mandate the necessity of a rate change.

Base rate adjustment will result in a new base rate component value(s) which will be used to calculate the new rate for the next year.

7. Rate Determination

a. Initial Calculation of the Rate Effective 10/1/89

Facilities are licensed through the Department of Health and Hospitals by level of care and capacity grouping. Each level of care within a capacity grouping has a specific flat rate. The initial base rates were developed from the July 1, 1987 issued rates, which were based on budgeted cost data from the approved rate setting methodology. Rates were grouped by capacity and level of care. After grouping the rates, the following procedures were applied:



1-8 BEDS

(1) An average per diem rate was determined for each group.
(2) An average fixed cost rate was determined for each group.
(3) The average fixed cost rate was subtracted from the per diem rate.
(4) Inflation as outlined in C.1.(a)and(b) was then applied to the non-fixed costs per diem rate. (Two years inflation added, 12/86-12/87 and 12/87-12/88.)
(5) Fixed cost rate was then added back to the inflated adjusted per diem.
(6) This resulted in a projected per diem rate for each level of care.

9-32 BEDS

(1) An average per diem rate was determined for each group.
(2) An average fixed cost rate was determined for each group.
(3) The average fixed cost rate was subtracted from the per diem rate.
(4) Inflation as outlined in C.1.(a)and(b) was then applied to the non-fixed costs per diem rate. (Two years inflation added, 12/86-12/87 and 12/87-12/88.)
(5) Fixed cost rate was then added back to the inflated adjusted per diem.
(6) An incentive of 20% was then added to the per diem rate to encourage downsizing in keeping with programmatic goals.
(7) This resulted in a projected per diem rate for each level of care.

33 PLUS BEDS

(1) An average per diem rate was determined for each group.
(2) An average fixed cost rate was determined for each group.
(3) The average fixed cost rate was subtracted from the per diem rate.
(4) Inflation as outlined in C.1.(a)and(b) was then applied to the non-fixed costs per diem rate. (Two years inflation added, 12/86-12/87 and 12/87-12/88.)
(5) Fixed cost rate was then added back to the inflated adjusted per diem.
(6) This resulted in a projected per diem rate for each level of care.

b. Exceptions to Rate Calculations

For those levels of care with no providers, 8% from the next highest LOC amount was calculated to determine a per diem rate.

8. a. Subsequent Rebasing of Rates for 7/1/94

Obtain total allowable costs from 91/92 audited and/or desk reviewed cost reports and divide by total client days to calculate average costs per day for facilities in each CAP/LOC grouping.

Separate costs into fixed costs and non-fixed costs categories.

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Apply inflation as outlined in C.1.(a)and(b)to non-fixed costs from the cost report period of July 1, 1991 through June 30, 1992 for the effective date of the rate change, July 1, 1994. (Two years inflation would be added for 7/1/94 rebased rates, 12/91-12/92 and 12/92-12/93.)

Add fixed costs to inflated non-fixed costs to determine the base rates.

Add 5% ROI to determine new rates.

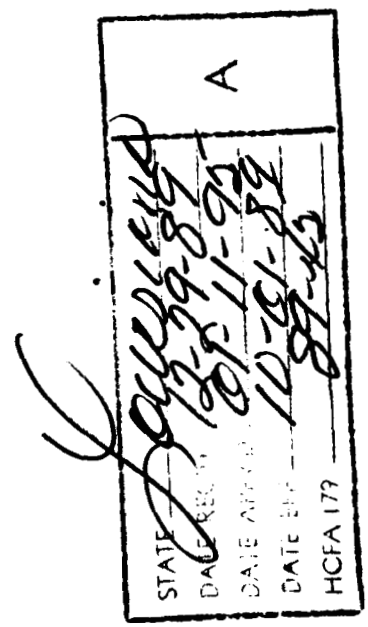
b. Exceptions to Rebasing of Rates for 7/1/94

For those levels of care with no providers, 8% from the next highest LOC amount will be used to determine a per diem rate.

Adjustments ~~can~~ Shall be made to rates by CAP/LOC for particular items of costs that have increased beyond the amount that normal inflation has been able to compensate.

Adjustments ~~can~~ Shall be made to rates by CAP/LOC for material changes in occupancy levels, but not below 80%.

These type adjustments shall be determined based on the aggregate for each CAP/LOC grouping. Adjustments that are not indicative to all CAP/LOC groupings shall be made only to the affected CAP/LOC.



9. Subsequent Rebasing of Rates

Obtain total allowable costs from most recent audited and/or desk reviewed cost reports and divide by total client days to calculate average costs per day for facilities in each CAP/LOC grouping.

Separate costs into fixed costs and non-fixed costs categories.

Apply inflation as outlined in C.1.(a)and(b) to non-fixed costs from the cost report period for the effective date of the rate change.

Add fixed costs to inflated non-fixed costs to determine the base rates.

Add 5% ROI to determine new rates.

For those levels of care with no providers, 8% from the next highest LOC amount will be used to determine a per diem rate.

Adjustments shall be made to rates by CAP/LOC for particular items of costs that have increased beyond the amount that normal inflation has been able to compensate.

Adjustments shall be made to rates by CAP/LOC for material changes in occupancy levels, but not below 80%.

These type adjustments shall be determined based on the aggregate for each CAP/LOC grouping. Adjustments that are not indicative to all CAP/LOC groupings shall be made only to the affected CAP/LOC.

During non-rebasing years, the current rates will be inflated as outlined in C. 1.(a) and (b) to non-fixed costs for the effective date of the rate change. Application of the inflationary adjustment shall apply only in years when the state legislature allocates funds for this purpose. The inflationary adjustment shall be made by applying the inflation factor applicable to the current fiscal year to the most recently paid non-fixed costs.

The Bureau of Health Services Financing will review rates annually to determine the need for rebasing rates. The rates shall be rebased when there is at least a 5% difference in comparing the total payments to facilities and the overall audited and/or desk reviewed cost of the same rate year.

10. Level of Care Appeals

Level of care determinations may be appealed by providers utilizing the same appeal process afforded to other long term care providers by the Bureau.

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11. EXTRAORDINARY COSTS

a. Definition of Extraordinary Care Costs

Extraordinary costs are costs incurred by a provider of services to meet a patient's daily needs as dictated by the Plan of Care (POC). These costs cannot be a duplication of basic services which have been reimbursed under the regular flat rate. These type costs are reimbursed outside the regular per diem payment through an enhanced amount on a recipient specific basis. Extraordinary care medical costs are defined as medical services which are not required for all patients at any level, but which are recipient specific, medically necessary and prescribed under an individual Plan of Care. Types of recipients who might require these extraordinary care services are mentally retarded children of drug abusers with severe and profound medical needs, individuals who have need of extraordinary care medical care services such as 24 hour licensed nurses, psychiatric intervention, special staffing requirements to implement intensive behavior therapy programs, etc. Other types of services which might be rendered under extraordinary care medical costs if not covered under the Medicaid card include services specific to medical needs such as special staffing, consultants' costs (e.g., psychologists, registered nurses, and occupational, physical and speech therapists, and medical services provided by specialists such as neurology, dermatology, psychiatry, gynecology, etc.). Included in extraordinary care medical costs are those costs associated with the delivery of an individual plan of care which is intensive in nature over a substantial period of time. These costs are not included under the facility's prospective flat rate; all costs relate to individualized programmatic needs. The Plan of Care must be reviewed and approved by the Department of Health and Hospitals. This rate does not include any costs not allowed under Medicare principles of cost reimbursement found in the Provider Reimbursement Manual (HIM-15).

b. Plan of Care

The Plan of Care is defined as an individual program plan developed by the Interdisciplinary Team based on current comprehensive functional assessments of strengths and needs with long range goals and time-limited objectives. Medically necessary types of services include, but are not limited to, such services as those itemized in the above paragraph.

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c. Application for Enhanced Rate

The facility must request the enhanced rate and provide documentation to support this request in order to ensure that funds for enhanced services are not available through another source.

The effective date of an enhanced rate will be the effective date of the POC.

Medicaid reimbursement of the extraordinary care medical cost shall be made only after the Department has reviewed and approved each Plan of Care and determined that the extraordinary medical services included are based on medical necessity and are not provided in the current regular per diem rate.

The client's situation and need for extraordinary care medical services is reviewed at least quarterly by the Interdisciplinary Team and Office for Citizens with Developmental Disabilities (OCDD) regional staff to determine the medical necessity of continuing the enhanced services and to determine if a fade plan for the enhanced rate based upon a reduced need for enhanced medical services is appropriate; if so, the time frame for the fade plan is documented in the recipient's record. The team makes a recommendation in writing regarding the need for continuation of the extraordinary care medical services provided under the enhanced rate.

At any time a provider determines that a client no longer qualifies for or is no longer in need of extraordinary care medical services, the provider is required to notify OCDD Regional Office and Bureau of Health Services Financing.

Copies of cost reports are submitted to the Regional Offices of OCDD. Copies of Health Standards surveys are available to monitors of recipients receiving extraordinary care services.

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